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RESEARCH ARTICLE

# European Long-Term Care Programs: Lessons for Community Living Assistance Services and Supports?

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**Objective.** To uncover lessons from abroad for Community Living Assistance Services and Supports (CLASS), a federally run voluntary public long-term care (LTC) insurance program created under the Accountable Care Act of 2010.

**Data Sources.** Program administrators and policy researchers from Austria, England, France, Germany, and the Netherlands.

**Study Design.** Qualitative methods focused on key parameters of cash for care: how programs set benefit levels; project expenditures; control administrative costs; regulate the use of benefits; and protect workers.

**Data Collection/Extraction Methods.** Structured discussions were conducted during an international conference of LTC experts, followed by personal meetings and individual correspondence.

**Principal Findings.** Germany's self-financing mandate and tight targeting of benefits have resulted in a solvent program with low premiums. Black markets for care are likely in the absence of regulation; France addresses this via a unique system ensuing legal payment of workers.

**Conclusions.** Programs in the five countries studied have lessons, both positive and negative, relevant to CLASS design.

**Key Words.** Cash for care, long-term care, aging, disability, health care financing

The 2010 Affordable Care Act (ACA) establishes the Community Living Assistance Services and Supports (CLASS), a publicly sponsored long-term care (LTC) insurance plan financed through voluntary premium payments. Because this financing approach is unprecedented, those implementing the law have no readily available models to emulate. This article examines programs that offer cash benefits—a key feature of CLASS—in Austria, Germany, the Netherlands, France, and England for their implications for the new program.

The European programs we analyze differ not only from CLASS but from one another. Participation is mandatory; some are financed out of general taxation, some out of premium payments, and some from both sources. Regardless of financing, all LTC financing schemes must balance revenues and expenditures, so we examine the challenges European programs have faced and whether the threats to solvency and the coping strategies deployed have potential implications for CLASS.

Because the CLASS legislation mandates cash benefits, we focus on countries operating substantial programs offering cash benefits. However, whereas all five European programs under discussion provide cash benefits either exclusively or as an alternative to "in-kind" services delivered by authorized service providers, the nature of their cash benefits varies considerably: not only in the monetary amounts countries provide but also in their expectations for how benefits will be used and in the extent of the restrictions imposed on, or accountability required for, cash benefit use. Advantages and disadvantages are associated with each of these variants of "cash for care" both across and within these European programs, which may provide creative inspiration—or cautionary warnings—for CLASS program design.

## METHODS

Our discussion draws on a literature review that included both academic journal articles and reports published by governmental agencies or international organizations, emphasizing those published in English within the past 5 years. This review led to a set of questions focusing on issues relevant to CLASS, which were explored with experts on European cash for care programs, brought together for two symposia at the September 2010 International Conference on Long-Term Care Policy (sponsored by the London School of Economics).

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*Will Premiums Deter Participation?*

One of CLASS's major challenges is whether voluntary program enrollment will be sufficient to overcome adverse selection and ensure long-term solvency (Miller 2011). Because cost is the major barrier to purchase of private LTC insurance (LifePlans, Inc 2007), it is critical that CLASS premiums are low enough that middle-aged, middle income Americans with many other financial priorities will pay them voluntarily. Despite the perceived high cost of the product, 10.7 percent of Americans aged 55 and older (12.5 percent of those 65 and older) are covered by private insurance (Johnson and Park 2011), at an average monthly premium of $160 (in 2005; LifePlans, Inc 2007.) Take-up rates of employer-sponsored LTC insurance, which has lower premiums due to the younger age of those covered, are in the 3–8 percent range (Tell 2011).

Germany's program most resembles CLASS insofar as the program must be financed solely from individual contributions and cannot be publicly subsidized (although Germans' contributions toward LTC insurance are mandatory, they are not considered "taxes" because 10 percent of the population purchases coverage from private insurers). Thus, the relationship between what participants pay and what they get is transparent. Currently, Germans contribute 1.95 percent of their income up to a maximum of $105 per month. The average German worker contributes $51 per month, half deducted from his or her paycheck; the other half is the "employer's share" (funded by employees' sacrifice of an annual paid holiday, under a political deal with employers). The self-employed and retirees with pension income pay the full amount.

In other countries, the cost of LTC coverage is less transparent because premiums are not the sole source of funding. In the Dutch "AWBZ" program, about a third of the financing comes from general revenues, rendering citizens' costs less transparent. The remaining two-thirds comes from individual contributions of 12.5 percent of income, split equally between employers and employees, up to a maximum of $474 (with the employee's share at $237) per month. The Dutch are currently considering major restructuring of the AWBZ program, including shifting all or most of the costs of "social" services (those not involving physical touch) out of the AWBZ to local social assistance, making access means-tested. This suggests that tax increases to sustain the program are no longer politically tolerable.

The costs of the other European countries' systems are even less obvious to the public: in Austria and England all program costs are taken from general revenues, while in France the majority is. On the other hand, because co-payments on the French Allocation Personalisee d'Autonomie (APA) allowance are

steeply income adjusted—low-income elders pay no co-payments, while higher income individuals pay co-payments of up to 90 percent—an estimated 30 percent of the French 60 and older (when they are eligible for the APA) purchase supplemental private LTC insurance, at an average cost of $43 per month (Vachey 2010).

The political acceptability of $50–100 per month mandatory contribution rates in Germany and the comparatively high take-up of supplemental private LTC insurance in France are potentially encouraging for CLASS. However, as we shall see, there are trade-offs to be made with respect to affordability and the amount, duration, and scope of coverage.

### *How Shall Benefits Be Targeted?*

In a voluntary program such as CLASS, affordable premiums are insufficient: coverage must also be attractive. Will it cover all the populations that the public would expect, at an adequate level and fair price? Perceptions about what "ought" to be included in the benefit are inescapably influenced by the context in which the program is situated: the cultural expectations about care and the other programs and services available to potential recipients, as well as societal decisions about how to target LTC spending (Da Roit and Le Bihan 2010). The question for CLASS is whether targeting benefits will limit enrollment to more high-risk individuals or whether offering coverage to broader populations will compromise program sustainability.

Although the German LTC insurance program serves all those who qualify regardless of age or diagnosis, eligibility is weighted toward those with needs for "hands-on" physical assistance and/or protective oversight related to dementia. Accordingly, over 80 percent of German LTC insurance claimants are age 65 or older; about 16 percent are adults under age 65, and 4–5 percent are children (Bundesministerium für Gesundheit [BMG] 2010) and, although (as in CLASS) coverage is "lifetime," the average claimant receives benefits for approximately 3.5 years. The CLASS legislation references similar criteria for eligibility; these are contained in the 1996 Health Insurance Portability and Accountability Act (HIPAA), which determines which private LTC insurance plans qualify as tax-exempt. In implementing CLASS, however, the Secretary of Health and Human Services (HHS) may deviate from these criteria: She could, for example, include additional benefit triggers that would provide benefits for those who lack a need for "hands on" assistance or supervision, including people with significant intellectual developmental disabilities.

A different approach was taken by the French APA program: it covers only non-institutionalized individuals 60 and older, with a separate (smaller and older) scheme for younger disabled adults. (Early plans for merging the two programs have been postponed indefinitely.) The Dutch program, on the other hand, covers people of all ages with all types of disabilities and conditions (including psychiatric conditions) in a range of settings, from institutions to homes. Whereas this breadth of coverage reflects principles of solidarity that are widely supported, Dutch officials report that it is challenging to meet the needs of such disparate subgroups within a single LTC program, albeit one with considerable flexibility built into its design.

Similarly, Austrian officials report that changes to their program are politically difficult because of the program's broad constituency base. The Austrian cash allowance is available regardless of age or type of disabling condition, but until recently it has primarily benefited the elderly. As of January 2009, however, assessment criteria were amended to better account for the needs of children and others with mental disabilities, including but not limited to dementia (Schneider and Trukeschitz 2008).

Will—or should—CLASS benefits be targeted to the elderly and people with disabilities, as in Germany and France? German assessment criteria favor age-related disabilities, while the French limit coverage to older people. (Inconsistent application of enrollment criteria in France, however, has been blamed for the program's excessive growth.) CLASS's legislative requirements already screen out minor children. Most important, the employment and earnings requirements for enrollment and 5-year "vesting" of benefits will screen out expensive-to-cover individuals with certain developmental and early-onset disabilities. On the other hand, assessment criteria that favor age-related disabilities (as the HIPAA criteria do) might balance out the risk that CLASS will disproportionately attract younger adults at higher, earlier risk of needing LTC, resulting in costlier premiums that would dampen enrollment among lower-risk individuals. Germans debate whether the current criteria are too narrow; but broadening the criteria would likely make it harder to maintain solvency, a consideration relevant to CLASS, as is the consistent and rigorous application of enrollment criteria.

### *What Is the Appropriate Level of Benefits?*

Long-term care insurance programs cannot be viewed in isolation (Colombo et al. 2011). Understanding the different contexts surrounding public LTC insurance programs helps to explain the wide variation in the monetary value

Table 1: Cash Benefits

| | | *Benefit Monthly, in American Dollars* | | *Benefit Level Varies by* | |
|---|---|---|---|---|---|
| | *Program* | *Average* | *Range* | *Income Level* | *Functional/ Health Status* |
| Austria | Pflegegeld | 642 | 222–2385 | No | Yes—7 levels |
| England | Direct Payments | NA | 71–1410 | Yes—means-tested and charges apply | Yes—assessed need |
| France | Allocation Personnalisée d'Autonomie | 711 | 39–1780 | Yes—copayments up to 90% of benefit | Yes—4 levels |
| Germany | Pflegegeld | NA | 324–986 | No | Yes—3 levels |
| Netherlands | Persoonsgebonden Budget | 1741 | 600–6600 | Yes—copayments apply | Yes—10 levels |

*Notes*. Benefit levels true as of 2010, except in the Netherlands, which are 2007 figures. Conversion rates based on April 2011.
Sources: Program administrators, Colombo et al. 2011.

of benefits. Table 1 shows the variation in benefit levels, while Table 2 shows how other programs complement each country's LTC program and the different roles played by cash benefits. Only in Austria and France are LTC benefits paid solely in cash: both Germany and the Netherlands allow recipients to opt for a cash benefit rather than an in-kind benefit—although the value of that benefit is, respectively, 50 and 25 percent less at each (severity-related) benefit level. Only in England may participants opt for cash benefits set at a value equivalent to in-kind services.

England is also the only country studied that does not use set benefit levels. Because, in Germany and the Netherlands, both in-kind and cash benefits are fixed monetary amounts, authorized providers of in-kind services can bill only up to the applicable monetary limit. In all countries but England, beneficiaries (of either in-kind or cash benefits) who want to supplement services must pay out of their pocket. British beneficiaries are not permitted to "top up" their benefits by paying privately, on the grounds that they receive all "necessary" care.

The minimum CLASS benefit—which must average at least $50 per day, or about $1,550 per month—compares favorably to benefits in four of the five programs studied, except the Netherlands', where the average payout is $1,682 per month. According to our Dutch informant, although 20 percent

Table 2: Benefits Available to Individuals Receiving Cash

| | *Care Recipient* | | | *Caregiver Benefits* | |
|---|---|---|---|---|---|
| | *Cash* | *Other Cash* | *In-kind* | *Cash* | *In-kind* |
| Austria | Pflegegeld | None | Means-tested services delivered at the local level: may include mobile services, outreach services, semi-institutional service, in-patient/ institutional services, services for persons with disabilities | Dementia care benefit (up to $288 per month). Supplement for 24 h care of $396–792 per month | Paid/unpaid leave, flexible working arrangements, pension credits, respite care, counseling, training, education |
| England | Direct Payments | Disability Living Allowance (under 65 years of age) from $31 to $198 per week, Attendance Allowance (65+) from $78 to $117 per week, Independent Living Fund (up to $777 per week) | Means-tested services delivered at the local level: may include residential care, day care, meal on wheels, home help, home adaptations | Means-tested Carers' Allowance of up to $137 per week | Pension rights and credits, information services |
| France | Allocation Personalisee d'Autonomie | Tax benefits (worth up to $810 per month); exemption from employer's taxes for 60+ individuals | Home help services | Tax benefits | 3 months unpaid leave |

*continued*

Table 2. *Continued*

| | *Care Recipient* | | | *Caregiver Benefits* | |
|---|---|---|---|---|---|
| | *Cash* | *Other Cash* | *In-kind* | *Cash* | *In-kind* |
| Germany | Pflegegeld | Technical aids and home modifications—up to $3,682 annually | Nursing home and outpatient services, care by volunteers, care at home, means-tested social assistance at local level | Up to $2,117 to cover respite for 4-week vacation | 4 weeks' vacation, up to 6 months unpaid leave, Social Security benefits, caregiver training, counseling, and support |
| Netherlands | Persoonsgebonden Budget | Annual supplement of $216–720 for those with chronic conditions | Rest homes, nursing homes, trans-mural care services | $360 annual allowance (tax-free), savings plan (1% of salary) | 2 weeks of leave at 70% of normal wages, up to 12 weeks unpaid leave |

*Notes*. Conversion rates based on April 2011.
Sources: Program administrators, Colombo et al. 2011.

of budget holders say the benefit did not cover needed services, 30 percent returned unspent funds at the year's end. In contrast, monthly cash benefits in Austria and France average $620 and $687, respectively. Statistics distinguishing between German in-kind and cash benefits are not available: however, cash benefits at the three disability severity levels range from $326 to $994. A total of 52.9 percent of all beneficiaries living at home are at level one, and 12 percent at level 3 (BMG 2011).

In each of the five countries, as in the United States, supplemental public benefits may be available (Table 2). Moreover, the programs' scopes of service differ. For example, the Dutch and German programs cover some nursing home costs (through in-kind benefits), while the French cash benefit can pay for services in residential care facilities (nursing homes and less intensive "retirement homes"). Cash benefits are only available to persons living at home in Austria and England. No country provides non-means-tested public funding for the "room and board" costs of nursing homes; in England, public funding for residential LTC is contingent on exhausting personal assets (including home equity).

Countries differ in citizens' preferences for formal services versus informal care; in their reliance on institutional or other forms of residential care; and whether paid aides are hired through highly regulated, professionally managed organizations or are individuals, possibly with little formal training, who are employed directly by beneficiaries or their families. Countries with higher formal service use tend to provide more generous benefits, both on average and with respect to the upper payment limit. Conversely, less generous benefits are more typical in countries whose citizens prefer family care, where benefits are primarily used to compensate family caregivers or pay individual providers, or as supplemental personal or household income.

In all countries, program administrators agreed strongly that public LTC insurance benefits are not meant to eliminate all reliance on informal help nor meet all functional assistance needs. For example, among German beneficiaries, 25 percent of those in nursing homes and less than 5 percent of those at home receive means-tested supplemental assistance (BMG 2008). As in the United States, the availability of locally financed supplemental benefits often varies by region and there may be waiting lists for services. U.K. benefits are determined at the local level, and their generosity varies widely, depending on the local government's finances and priorities.

In the Netherlands, the preference for formal services is pronounced. When the AWBZ LTC insurance scheme was established in 1968, it was

widely believed that, over time, publicly funded formal services would largely replace informal eldercare. By the time Dutch officials realized (in the 1980s) that demographic trends made this goal unrealistic, the public expectation of relying primarily on publicly funded formal LTC had taken root; thus, 90 percent of Dutch claimants choose the in-kind benefit (Schut and Van den Berg 2010). Even among those who choose the cash benefit, a substantial minority uses it to buy formal services from the same providers who are authorized to claim in-kind benefit coverage, to avoid waiting lists. Moreover, these beneficiaries may get better value for money by purchasing services from smaller and less expensive formal service providers.

In contrast, 79 percent of German home care beneficiaries (and 47.4 percent of LTC insurance beneficiaries, including nursing home residents) choose the cash benefit (BMG 2011). To understand how the cash allowance is spent, German officials conducted a 2010 survey, which revealed a strong preference for care from family members, friends, neighbors, and community volunteers. Most beneficiaries said they chose cash because they wanted to receive personal care from family rather than from "strangers"; family caregivers agreed. Many respondents—31 percent overall and 49 percent at the highest level of disability—reported using the benefit for basic living expenses (Schmidt and Schneekloth 2011). It is likely that less well-off beneficiaries use the cash benefit to substitute for or supplement means-tested cash assistance, whereas others may use it to enjoy a higher standard of living and better quality of life. Satisfaction with the program is fairly high: the German Ministry of Health's most recent survey found that 10 percent of beneficiaries reported that they were "very" contented, while 54 percent said they were "contented," 26 percent "less contented," and 8 percent "not contented" (BMG 2010b.)

The German LTC benefits have been criticized as too low, offering only a token reward to family caregivers. Although cash benefits do not compensate for the loss of a caregiver's job, they can provide untaxed income. Moreover, when family caregivers provide more than 14 hours of assistance per week the LTC insurance program pays into the pension, health insurance, and unemployment funds on their behalf. Critics accordingly charge that the German (and Austrian) system's cash benefits promote reliance on informal family care, reinforce traditional gender roles, provide disincentives to female labor force participation, and depress growth of the formal services sector (Österle and Hammer 2007; Da Roit and Le Bihan 2010). This arguably impedes professionalization of home care workers, making it harder to improve quality of care and gain workers higher pay and status. And yet the strong preference for cash benefits and reliance on family caregiving

genuinely reflects cultural norms—and serves to keep program costs and insurance premiums low.

However, some argue that inadequate benefit levels in German and Austria have created a market for large numbers of foreign home care workers —often migrants who are not protected by tax, labor, or immigration law—as well as a two-tiered system whereby better-off individuals can employ trained professionals, but lower income individuals rely on migrants. In Germany, there are an estimated 100,000 illegally employed home care aides, many of whom are migrants (Bundesverband privater Anbieter 2007). In Austria, use of the cash benefit to pay such workers reached an intolerable level, with about 40,000 illegal workers serving roughly 400,000 beneficiaries, prompting legal reforms of uncertain effectiveness.

### *Should Uses of the Cash Benefit Be Restricted?*

Governments face trade-offs when they try to control the use of cash benefits: although mechanisms to enforce restrictions can be costly, failure to control the use of cash benefits can result in cost overruns, public backlash due to perceptions of fraud and abuse, and the growth of a black market in care. The CLASS legislation sends mixed messages about the need to monitor the use of benefits. Beneficiaries are required to keep receipts, which either will or could be (the language is unclear) audited when they are reassessed for continued eligibility or for changes in benefit amount. Program administrators are required to report rates of fraud and abuse, data that will presumably be derived from audits; but since the legislation fails to define inappropriate benefit use, program administrators are left to define it (or not). The ability to monitor the use of benefits may be constrained, however, by the legislation's 3 percent cap on administrative expenses.

European LTC programs vary greatly in their approaches to beneficiary accountability. Both Austria and Germany lack restrictions on the use of the cash benefit and there is reportedly little interest in imposing any. However, program administrators are interested in understanding more about how benefits are being used (whether for LTC or basic living expenses). In Germany, because of concerns that cash benefits increase the risk of financial exploitation, neglect, mistreatment, or simply insufficient and poor quality care, all cash benefit recipients receive in-home visits at least every 6 months to assess the quality of care, conducted by professional home care providers. No data exist, however, on the impact of these visits and how often corrective actions are taken. Recipients of in-kind services are also subject to quality inspections,

although on a random basis. Similarly, in Austria, benefits may be canceled if abuse is found, but this option is rarely, if ever, exercised.

In both the Netherlands and France, use of the benefit is more restricted. In the Netherlands, less than 10 percent of the cash benefit can be spent as the individual wishes; the remainder must be used to purchase human assistance (aide services), including family members. In France, use of the cash benefit is highly regulated. Local geriatric assessment teams are responsible for benefit determinations and setting service plans. Beneficiaries have the right to provide input on the plan, but once the team has prescribed a service plan, it must be followed or benefits must be declined. Although the team may prescribe a wide range of disability-related goods and services (including assistive technologies and home modifications), 93 percent of service plans prescribe only human assistance (Vachey 2010). Beneficiaries are free to obtain aide services from formal provider organizations or they may independently employ aides (including any relatives but spouses).

The Netherlands and France have been effective in preventing cash benefits from encouraging a black market in home care workers. All individually employed aides (including family members) must be paid in accordance with the law. Beneficiaries must report on and provide identifying information on the workers they employ; moreover, they must keep receipts proving that they have paid their workers legally, including making required tax payments. In the Netherlands, beneficiaries can either make the filings and payments themselves or access help in doing so. However, through the "Chèques Emploi Service Universel" (CESU), France has developed a simple, effective method of ensuring compliance with employment law among employers of individual service workers (who include not just home care workers paid with APA benefits, but other domestic service workers, such as nannies, cleaners, gardeners, and others, paid from both public and private funds). Special checkbooks for paying workers include vouchers that are sent to the national tax processing center, which computes taxes owed and periodically debits the employer's bank account.

England operates several programs offering cash benefits, some of which impose more restrictions, professional oversight, and accountability for how funds are spent than others. However, all these programs allow much more "consumer-directed" flexibility and creativity in the use of personal budgets to meet assistance needs than the French or Dutch programs do. The purchase of non-traditional goods and services is actively encouraged, so long as they serve to meet disability-related needs, which may include meeting goals of independence and autonomy. Beneficiaries are held accountable for their

support plan and must produce receipts documenting expenditures as well as prove that they have met their legal obligations as employers. Employing family members who reside in the beneficiary's household as service providers is strongly discouraged (spouses are unilaterally excluded).

### *Can Administrative Expenditures Be Kept Low?*

One of the biggest challenges posed by the CLASS legislation is its cap on administrative expenses of 3 percent of revenues. The rationale is to keep premiums levels low to attract enrollees, while at the same time maximizing benefits, although there is significant concern that the 3 percent figure is unrealistically low. The European experience suggests that the 3 percent figure may not be impossible to reach. Comparing administrative costs across different countries' programs is difficult, however. Some countries do not collect relevant data, while others split their administrative functions across levels of government. Austrian officials estimated their administrative expense at roughly 3 percent, but they admitted that this estimate was not based on firm data. In France, while the national administrative body is able to calculate that administrative costs related to the APA are 0.5 percent of benefits, information on local administrative costs is less reliable: an informal audit of six local authorities estimated them at 3–5 percent of benefits. Only Germany has complete information; it operates under a 3.5 percent cap on administrative expenses.

However, comparing administrative costs can be difficult, due to the fungible nature of administrative functions. The list of potential "administrative" functions includes some that are critical for CLASS and more burdensome than those faced by universal mandatory insurance programs: marketing and enrollment, keeping track of vesting and lapses, and actuarial work monitoring and predicting program solvency, as well as other functions such as case management, quality assurance, and monitoring use of the cash benefit. Although the CLASS legislation limits flexibility by defining certain services (e.g., information and referral, legal assistance) as administrative and therefore subject the cost cap, CLASS may be able to learn from how other countries creatively define and shift program costs to the "benefit" rather than the "administrative" side of the accounting ledger.

All five European LTC programs see assessment as a core program administrative function; however, the availability of case management or other forms of advice and assistance is quite variable. Such assistance is not part of the Austrian program, whereas in France it is required and both paid

for and provided by local government. In England, cash beneficiaries can use benefits to purchase assistance with managing budgets and making decisions about which services to purchase. In Control, a national non-profit organization that pioneered self-direction in Britain, offers an on-line resource (http://www.in-control.org.uk/what-we-do/shop4support.aspxs) to help beneficiaries locate assistance. In the Netherlands, several non-profit, consumer-run organizations support personal budget holders; however, for-profit "care mediation" companies have arisen, which engage in controversial self-referral practices whereby care managers steer budget holders toward their parent company's home care services. In Germany, many "supportive" services for LTC program beneficiaries and their family caregivers are treated as extra benefits. In 2008, a popular voluntary case management service became available to both in-kind and cash beneficiaries, funded equally by benefits and program administration funds.

CLASS could also learn from the ways that other countries find efficiencies by coordinating with other public programs or non-government organizations. In Germany, for example, some service information/referral and case management services are available through local "one-stops" (similar to Older Americans Act-funded area agencies on aging and aging/disability resource centers). LTC insurance funds are required to participate. In the Netherlands, personal budget holders can use funds to pay dues to a consumer-run budget-holders' association called Per Saldo, one of many "patient associations" supported both by dues and government-funded patient self-advocacy grants. Because Per Saldo provides a wide range of supportive services (including help locating service providers, peer counseling, and legal assistance), the LTC insurance program does not have to. Similarly, in England, Centers for Independent Living and other voluntary organizations provide important support to cash recipients.

### *Can CLASS Maintain Solvency?*

Solvency has been a challenge for all the countries studied. Figures 1 and 2 show enrollment and expenditures for the five countries. Germany has been most successful in controlling growth, perhaps because it, like CLASS, is required by law be self-financing. Officials attribute this success to two factors: an assessment process that is strict but reliable and widely perceived to be fair, and quick action to address threats to solvency, allowing officials to make minor adjustments. For example, in 2008, the contribution rate was increased from 1.7 to 1.95 percent (2.2 percent for childless individuals). In addition to

Figure 1: Annual Expenditures, in U.S. Dollars, 2000-2008. Sources: Austrian Data from BMASK; English Data from Quality Care Commission, 2010; French Data from DREES, 2010; German Data from Schulz 2010; Dutch Data, Personal Correspondence 2010

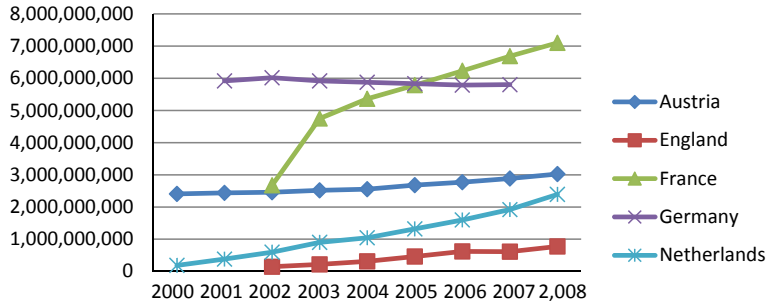
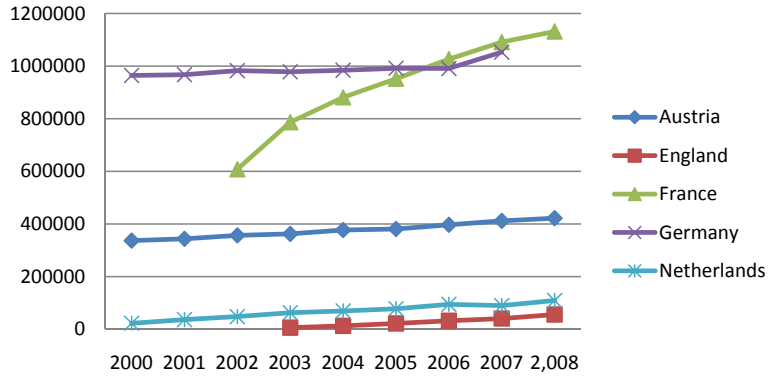



Figure 2: Annual Enrollment, 2000-2008. Sources: Austrian Data from BMASK; English Data from Quality Care Commission, 2010; French Data from DREES, 2010; German Data from Schulz 2010; Dutch Data, Personal Correspondence 2010




aiding solvency, the rate increase addressed public dissatisfaction with the eroding value of the benefit, a deal sweetened by adding special purpose benefits (e.g., a dementia benefit and access to case management) (Arntz and Thomsen 2011).

The main threat to the German program's solvency is demographic: in a pay-as-you-go system financed primarily by the gainfully employed, the decreasing number of working age adults relative to retirees is a cause for concern. It is projected that mandatory contributions will need to increase

from today's 1.95 to 2.3 percent by the year 2030 (BMG 2008). A major debate is now ongoing about whether the system needs to be restructured and "capitalized" such that contributors will be required to pay more toward the costs of future benefits.

The Netherlands and France are both coping with serious solvency issues. Ten-year enrollment in the French APA far exceeded initial projections in 2003—1.2 rather than 0.8 million. Because the program is in deficit, it is universally acknowledged that a major structural reform will have to take place, although proposed solutions are politically unpalatable. Assets as well as income may be considered in determining co-payments; estate recovery measures may also be re-introduced. Another option is to further encourage France's already healthy market for private LTC insurance.

In the Netherlands, financing crises have recurred over the more than 40-year history of the AWBZ insurance scheme, becoming so acute that, in 2011, waiting lists were imposed. Until recently personal budgets were seen as a solution to over-spending, due to the lower rate of payout relative to in-kind benefits. However, there is now concern that the cash benefit might be attracting a new market—persons with intellectual developmental disabilities and serious mental illness—that developed as a result of local governments' success in controlling disability insurance costs and shifting demand to the AWBZ program. In addition, personal budgets are now seen as a way for recipients to avoid waiting lists for formal services, enabling the direct purchase of services with cash. Thus, financing problems in the AWBZ are to some extent a reflection of systemic issues in the Netherlands.

## CONCLUSION

The widely varying systems for financing and structuring LTC insurance programs illustrate some of the important issues that policy makers face when attempting to meet the ever-growing need for long-term services and supports. How these issues are resolved reflect political priorities, cultural expectations, and the services available through other public programs in each country—but they also provide lessons that may help CLASS to succeed. All countries face the need to maintain solvency, whether a self-financing requirement is enforced via statute—as it is for CLASS and the German program—or through political pressure; they also face the host of issues associated with cash benefits and address them (or not) in different ways.

Each country offers lessons: The Dutch experience represents a cautionary tale about the need to target benefits and be conscious of potential cost-shifting from other programs. It also shows that appropriate regulation can prevent the development of a black market in care, while the black markets in Austrian and German demonstrate the consequences of regulatory inaction. Luckily, the French appear to have developed a mechanism to address this, via their CESU payment system. The countries also demonstrate a range of approaches to the issue of oversight and accountability for the use of benefits: in England, uses are broad but accountability is tight; the French restrict the use of the benefit but have high levels of accountability; the Dutch represent a middle ground; and the Germans and Austrians have very little oversight and accountability.

The range of responses to the need for LTC coverage, and the range of public tolerance for different contribution levels—from the high premiums paid in the Netherlands, to the substantial copayments and supplementation of the benefit via private LTC insurance demonstrated by the French, to the low premiums paid by the Germans—suggest that perhaps such a range of preferences exists here in the United States. Indeed, several U.S. experts in private LTC insurance recently noted that its sales have plateaued and are unlikely to increase so long as only "Cadillac" (i.e., luxury) products are offered (National Health Policy Forum 2011). Such products are marketed as protection against the depletion of assets due to long nursing home stays (at an average cost of $75,000 a year), a motivation that is hardly mentioned in European discussions of the role of public LTC coverage—quite rightly, as the available public coverage would be inadequate to serve this purpose. Nevertheless, in Germany, for example, LTC coverage reduced the percentage of nursing home residents who need to apply for "welfare" to help cover the costs of nursing home care decreased quite substantially (from nearly 46 percent in 1995 to 29 percent in 2010; BMG 2008). In Europe, the aim of LTC coverage has been to reduce the burden on unpaid family care by providing limited financial compensation for family caregivers or by enabling access to formal services. European experience suggests, at the very least, that CLASS could appeal to an untapped market for a more modest, basic form of coverage—something more akin to a good quality affordable economy car like the Ford Fiesta than to a "Cadillac" private insurance targeted at a niche market of wealthy Americans.

CLASS shares with the German LTC insurance program the need to self-finance and charge premiums that make participants' contributions—and the link to the benefits they receive—utterly transparent. In Germany, these characteristics appear to have imposed a discipline that has insulated the

program from the political pressures that have made it difficult for the other European programs that depend on general revenues to balance their books. Thus, Germany's 16-year success in remaining solvent provides some grounds for optimism for CLASS.

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## SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.

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